

15130

FILED MAY 5 1953

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 5885		Registrar's No. 18	
1. PLACE OF DEATH a. COUNTY OSAGE				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY OSAGE			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BONNOTS MILL		c. LENGTH OF STAY (In this place) Linn Twp LIFE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BONNOTS MILL		Linn Township	
d. FULL NAME OF HOSPITAL OR INSTITUTION BONNOTS MILL R.D.				d. STREET ADDRESS (If rural, give location) 0760			
3. NAME OF DECEASED (Type or Print) CATHERINE		a. (First)		b. (Middle)		c. (Last) BROECKER	
4. DATE OF DEATH		APRIL 23 1953		5. SEX female		6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH Jan 19-1866		9. AGE (In years last birthday) 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
11. BIRTHPLACE (City and State or Foreign Country) Loose Creek Mo		12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Antone Strope		13b. MOTHER'S MAIDEN NAME Elizebeth Schaefer	
14. NAME OF HUSBAND OR WIFE Theo. Broecker (Dec)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT'S SIGNATURE OR NAME Miss Louise Broecker	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>  ANTECEDENT CAUSES <u>Bad rest &amp; inactivity</u>  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture of hip</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. DATE OF OPERATION 19a. DATE OF OPERATION	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>Feb.</u> , 19 <u>53</u> to <u>APRIL</u> , 19 <u>53</u> that I last saw the deceased alive on <u>April 23</u> , 19 <u>53</u> and that death occurred at _____ m.; from the causes and on the date stated above.		23a. SIGNATURE <u>Lawrence Everett Jeffers</u>	
23b. ADDRESS <u>Jefferson Ct</u>		23c. DATE SIGNED <u>4/26/53</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>April 27/1953</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Frankenstine Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Frankenstine Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Clyde Martin</u>		25. ADDRESS <u>Linn Mo</u>	
DATE REC'D BY LOCAL REG. <u>May 2-1953</u>		REGISTRAR'S SIGNATURE <u>Ta. Anderson</u>		26. DATE <u>2 35</u>		27. TIME <u>0</u>	

(Licensed Embalmer's Statement on Reverse Side)

**WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD**

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by\_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....

Student Embalmer

Signed

*Urban M. Merton*

Licensed Embalmer No. *4125*

P. O. Address *Linn, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.